



LOS ANGELES COUNTY COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

June 18, 2015

Approved
7/16/2015

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Grissel Granados, MSW, Co-Chair	Fariba Younai, DDS, Co-Chair	Bill Brown	Jane Nachazel
Raquel Cataldo	Derek Dangerfield	Melissa Fisk	Doris Reed
Kevin Donnelly	Suzette Flynn	Lambert Talley	
David Giugni	Kimler Gutierrez	John Thompson	
Terry Goddard, MA	John Palomo	Octavio Vallejo	DHSP STAFF
Michael Johnson, Esq.	Maria Roman		Wendy Garland, MPH
Carlos Vega-Matos, MPA			Sophia Rumanes, MPH
			Amy Wohl, MPH, PhD

CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Standards and Best Practices (SBP) Committee Agenda, 6/18/2015
- 2) **PowerPoint:** Linkage to, Re-engagement in and Retention in HIV Medical Care, Overview, 6/18/2015

1. **CALL TO ORDER:** Ms. Granados called the meeting to order at 10:00 am.

2. **APPROVAL OF AGENDA:**

MOTION #1: Approve the Agenda Order, as presented or revised (**Passed by Consensus**).

3. **APPROVAL OF MEETING MINUTES:**

Motion 2: Approve the Standards and Best Practices (SBP) Committee meeting minutes, as presented or revised (**Postponed**).

4. **PUBLIC COMMENT, (Non-Agendized or Follow-Up):** There were no comments.

5. **COMMITTEE COMMENT, (Non-Agendized or Follow-Up):** There were no comments.

6. **CO-CHAIRS' REPORT:** There was no report.

7. **COMMITTEE CO-CHAIR ELECTIONS:**

▪ Nominees were Mr. Goddard and Dr. Younia. Mr. Donnelly withdrew his nomination.

MOTION #3: Elect Mr. Goddard and Dr. Younia to one-year term as SBP Co-Chairs (**Passed by Consensus**).

8. **LINKAGE TO CARE (LTC) AND RE-ENGAGEMENT PRESENTATION:**

- Dr. Wohl, Chief, Research and Innovation, and Acting Chief, HIV/STD Surveillance, DHSP, and Ms. Rumanes, Chief, Prevention Services, DHSP, presented with a PowerPoint on Linkage to Care (LTC) and Re-engagement in HIV Medical Care.
- They reviewed current Testing, Linkage, Care and Treatment (TLC+) programs including the DHSP/APLA SIF Navigation Pilot Program and DHSP's Project Engage funded by CDC and some other funders. High impact prevention is a CDC core activity.
- The CDC estimates 14%, or 8,352, of the estimated 59,660 PLWH in the County are unaware of their HIV+ infection. The estimate is based on national data and has decreased over time. Some subgroups have higher or lower estimates. DHSP

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was working with the CDC to refine data, e.g., African-American MSM have a notably higher rate. The overall County rate per 100,000 was 18, but varies by SPA, e.g., SPA 4 has a rate of 53 and SPA 5 has a rate of 23.

- HRSA defines retention in care as two laboratory tests at least 90 days apart within a 12 month period which is also the RW Ambulatory Outpatient Medical (AOM) standard. Anecdotally, providers report compliant, long-term virally suppressed patients may only visit once per year. While not the standard of care, it may explain lower white and male retention rates.
- Mr. Vega-Matos added, based on provider reports, overall AOM visits per year have declined from 4.5 to 3 visits. AOM monitoring includes chart review and reflects that over 80% of RW AOM patients were virally suppressed. Due to ACA, many RW AOM patients reflected in the 2013 data have migrated to other payer sources. DHSP hoped to continue monitoring their retention and viral suppression. Many remain in the same medical homes, but others do not. Ms. Garland noted if data shows patients did better under RW AOM that could be used to argue for RW Standards of Care (SOCs).
- Mr. Goddard suggested sharing best practices. Mr. Vega-Matos said DHSP works closely with LA Care especially to facilitate Medical Care Coordination (MCC) access, but Health Net was less open. Ms. Rumanes added plan approaches to an item may differ, e.g., RW tests multiple sites for gonorrhea, but most clinics are paid for one test so do not test entogenous sites.
- DHSP funds 10 TLC+ programs which ensure patients testing HIV+ are linked to medical care. The CDC also directly funds 11 programs which now require a navigator linkage specialist, a possible challenge for programs without a medical clinic. These new CDC contracts require identifying medical providers to work with, but DHSP has shared with CDC that patients should be able to choose their provider for effective linkage rather than being directed to only one or two.
- Mr. Vallejo suggested capacity building to train the many testing and counseling staff not familiar with LTC. Ms. Rumanes said DHSP staff are finding many prevention staff are not as comfortable discussing medical care with patients and that they are unfamiliar with navigating the health care landscape or coordinating, e.g., benefits and transportation.
- Mr. Vega-Matos added the CDC does not fully understand health care complexity in California. For example, many states have statewide ACA health plans, but LA County alone has two health regions within the market exchange and six health plans. Ms. Rumanes noted California law is also more restrictive than in most states, e.g., on sharing surveillance data.
- Mr. Goddard said housing as intervention is being discussed as a possible Cascade improvement and New York published a study showing it increased retention and adherence. He asked about CDC or DHSP review of housing to improve outcomes. Mr. Vega-Matos noted the Commission just approved recommendations to increase residential care services while HOPWA addresses Section 8. DHSP considers housing a social determinant of health and navigators address it as a barrier to care.
- RW and Substance Abuse Prevention and Control are the two Department of Public Health (DPH) programs that fund residential care. DPH also has a Homeless Task Force primarily to inform and enforce regulations. Mr. Johnson noted the Department of Health Services' mission is broader than that of DPH and could address potential savings via housing for its 250,000 medical care patients. He felt the Commission could advocate for DHS to link housing into care.
- Dr. Wohl reported DHSP has conducted two demonstration projects in the last couple of years to test and evaluate methods to improve identification, linkage and re-engagement of PLWH not in care.
- DHSP matched funds that AIDS Project Los Angeles (APLA) received from the Social Innovation Fund for the DHSP/APLA Navigation Project. The Project used APLA contact staff as navigators while DHSP used surveillance data and Public Health Investigators to identify adult, current or prior PLWH out of care patients at seven HIV clinics.
- DHSP screened information on 1,139 patients identified as lost to care from medical records. The largest percentage, 36%, were in care elsewhere while 8% returned to care on their own, 7% had left the County, 3% were institutionalized, and 6% were deceased. Despite extensive research in surveillance and other databases, 29% could not be located. Of the remainder, 7% were enrolled in care and the final 4% declined enrollment.
- Dr. Wohl said it would be very difficult for a clinic to attempt this kind of program without DPH assistance in examining surveillance data. County Counsel has advised DHSP it can inform a clinic that a patient is in care at another clinic, but cannot disclose the clinic's name or other data. DHSP itself cannot identify the funding source of care from surveillance.
- Ms. Fisk was concerned about PLWH on the edge of "out of care," e.g., someone with inconsistent care. Dr. Wohl replied surveillance data reflects the entire patient's history. DHSP worked with providers to identify those needing assistance.
- Navigators met with patients an average 4.5 times over an average 10.6 weeks to identify barriers to linkage to care and develop an action plan to help manage barriers in preparation for care engagement, as needed. The navigator's goal was to provide a warm handoff to an established Medical Care Coordination (MCC), but MCC was not well established at the start of the Project so navigators performed some work later assumed by MCC teams. Retention at 12 months was 82%.
- Mr. Vallejo felt the 29% of PLWH who could not be located highlight a key need. Dr. Wohl said the figure is consistent with the experience of other jurisdictions attempting to find lost to care populations. DHSP had access to virtually all contact

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information, but a sizeable subset of PLWH are very marginalized, e.g., homeless or recently incarcerated. Some patients also move back and forth between the County and Mexico or other states not all of which have laboratory reporting.

- Ms. Rumanes said DHSP continues to urge clinic staff to get contact information. Mr. Vega-Matos added DHSP has found five cases of PLWH in Casewatch with different names, contact information and insurance data. Mr. Vallejo said the undocumented may give different information because a record of public health care use can bar them from citizenship.
- DHSP's other demonstration project, Project Engage, specifically targets particularly hard to reach PLWH. Individuals, "seeds," are identified who know people in the target population within their social networks. Both seeds and a recruited patient linked to care received \$40. Recruited patients, "alters," then become seeds themselves.
- Key goals were to compare recruitment methods and determine cost effectiveness so staff also went into the field to directly recruit marginalized out of care PLWH. Palm cards and posters were also widely distributed.
- The Project launched in October 2012 initially via the LA LGBT Center and the Oasis Clinic, but found PLWH in care are less likely to know PLWH out of care than those out of care themselves. This population reflected higher percentages of social determinant barriers to care: homelessness, 75%; recent incarceration, 52%; IDU, 46%; MSM/IDU, 31%; engaged in sex work, 29%; and had an average of 7.9 service gaps with an average 14.3 months out of care. Despite these barriers,, 69% re-engaged in care and 56% were retained. Re-engagement is labor intensive averaging 7.8 hours over 43.6 days per person.
- Of those linked to care, viral suppression percentages were: pre-enrollment, 31%; re-engagement (one medical visit), 26%; retention (second medical visit six months after re-engagement), 41%. Dr. Wohl said some patients were likely obtaining medication from physician's continuing prescriptions, intermittent clinic visits or from other people.
- Lessons learned from the two Projects inform a larger County-based Linkage and Re-engagement Program (LRP). Ms. Rumanes added DHSP is not as involved in retention because that is primarily done by medical clinics.
- DHSP found surveillance data critical to target those most in need of LRP. The law changed two years ago to allow use of such data for public health purposes, but in a limited way. Coordination with providers is also needed for navigator work.
- The new LRP includes four branches with: clinic-based services, jail-based services, agency/provider referral and outreach/social network referral. A three-tiered patient navigation approach ensures PLWH receive needed support: 1. direct LTC; 2. motivational interviewing; and 3. modified ARTAS with strengths-based case management interventions. Follow-up ensures a directly linked patient (Level 1) receives Level 2 or 3 services if his/her first appointment is missed.
- Mr. Vega-Matos added traditionally community partners brought people into care. Coordination with public health is now important in order to access the surveillance data needed to locate and link to care the most marginalized populations.
- LRP will be rolling out in July 2015. Ms. Rumanes noted that generally clinics and emergency rooms are reluctant to initiate routine testing until they are able to incorporate linkage so roll out is expected to increase testing.
- Mr. Johnson suggested discussion among DHSP, the Planning, Priorities and Allocations Committee and SBP regarding DHSP assuming all linkage responsibilities. While it cannot disclose surveillance data to clinics, he felt it could link patients to care.
- Mr. Vega-Matos replied work is continuing to integrate LRP services into the currently identified system.
- There is also a question of advocacy. To date, HRSA has agreed that RW Part C and D directly funded providers must obtain a letter of concurrence from DHSP for their grant applications. DHSP requires their program information and budgets to provide the letter which allows DHSP to, e.g., identify duplicative services. Two providers did not receive letters in the last cycle because DHSP did not receive materials. The RW Project Officer also now calls DHSP if duplications are noted.
- The CDC is not addressing coordination as fully as HRSA is, however, so DHSP knowledge of CDC-funded programs is limited.

9. NEXT STEPS:

- A. **Task/Assignment Recap:** There was no further discussion.

- B. **Agenda Development for Next Meeting(s):**

- ⌚ 7/16/2015: Agendize discussion of how to create a DHSP function to do outreach, collaboration and coordination with all partners engaged in a service.

10. ANNOUNCEMENTS: Mr. Donnelly was running for Consumer Caucus Co-Chair.

11. ADJOURNMENT: The meeting adjourned at 12:00 noon.